Adopted December 12, 1997 by the Managed Health Care Improvement Task Force

EXPANDING CONSUMER CHOICE OF HEALTH PLANS
FINDINGS AND RECOMMENDATIONS

I. PRINCIPLES

In a system of managed health care plans that limit patients' choices of providers, choice of health plan[1] at the individual or family level is very important. Choice may be or is required: (1) to maintain ongoing provider-patient relationships, (2) to facilitate patient willingness to work with his or her provider, (3) to improve consumer satisfaction with health plans and the health system (studies show that people with choice are more satisfied), and (4) to allow competition at the individual subscriber level to discipline price.

For these reasons, ideally every individual or family should have a multiple choice of health plans that includes a variety of HMOs, PPOs, and other options such as is provided to state and other public agency employees participating in the California Public Employees Retirement System. Achieving the full benefits of competition would also require every individual and family to have economic responsibility for premium price differences, comparative quality information, and some standardization of benefits within groups.

II. CHOICE IN CALIFORNIA TODAY

In California today, more employed individuals have choice of plans than the national average, though employees of smaller firms are less likely to have choices than employees of larger firms, according to KPMG Peat Marwick data. Data provided to the Task Force by KPMG indicates that approximately 55% of employed individuals in California whose employers provide health care coverage are offered a choice of two or more plans by their own employer. Taking into account options through both spouses' employers would increase substantially the proportion of those offered multiple plan choices. On this basis, the Managed Health Care Improvement Task Force public survey found that approximately 75% of consumers in California who knew the number of choices they were offered reported that they had a choice of more than one plan (See Task Force paper on Public Perceptions and Experiences with Managed Care).

Even though Californians have greater choice of plans than the national average, fewer working Californians have access to a health plan that provides unlimited choice of provider than workers nationally. In addition, where employees have a choice of plan, it is often a choice of plan model type rather than multiple choices within one model. This is positive in that some individuals in a group might prefer, for example, an HMO, while others prefer a PPO. However, choices among plan model types set up a less competitive situation among health plans because individuals are less willing to switch among them than among plans of the same model type[2].

III. OBSTACLES TO CHOICE

Individuals (not in groups) theoretically have an unlimited choice of coverage options, as long as they are willing to shop around and pay the market price. However, in practice their choice may be much more limited due to reasons of access (e.g., plans often will not sell individual policies to persons who are or are

[1] Throughout this paper the term health plan is used to mean health insurance arrangements offered by an insurer, employer, health maintenance organization (HMO), or other managed care organization, also known as health benefits financial intermediaries.

[2] Royalty A and Solomon N, "Health Plan Choice: Price Elasticities in a Managed Competition Setting", May 1997, working paper.

perceived to be unhealthy or high risk individuals.[3] It has proven particularly difficult to guarantee access to coverage and choice of plans to unaffiliated individuals in a system of voluntary health insurance because of the particularly acute problem of adverse selection in the individual market and attendant premium increases or "death spirals" that can occur when no rate structure is established and public reinsurance is not in place. Some states have attempted to adopt mitigating protections against this occurrence as part of health insurance reform initiatives, but for political reasons, many have not been able to put the safeguards into their market reforms that would make them more stable (such as open enrollment periods, the use of pre-existing condition exclusion periods, and statewide reinsurance).[4] In the absence of such safeguards, the State of Washington experienced a 72%[5] average increase in its state sponsored Basic Health Plan premiums from 1997 to 1998, and maternity rates seven times greater than the general population in 1998, after implementation of guaranteed issue in the individual market that replaced the state's high risk pool and included just a three-month pre-existing condition exclusion. The impact of guaranteed issue on premium increases in Massachusetts was also significant.[6]

Employers in the small group market typically offer choice of plan least often because (1) some health plans refuse to participate in multiple choice situations with small employers, (2) employers face additional administrative burdens when offering multiple plans, and (3) employers prefer to offer their whole group to one insurer in exchange for the best rates possible today, even though this may weaken the health plan's incentive to reduce rates in the future (unless an employer is willing to switch plans, which some may be).

In 1993, AB 1672 established rules in the small group market (currently 2-50 employees) in response to problems of access to choice of plans. Data indicates that employers in the mid-size market also offer their employees few choices of health plans.[7] Some have suggested that an expansion of these rules to the mid-size market (groups of 51-100) would encourage formation of purchasing groups and ensure a wider array of choices offered within employment groups. A recent University of California report and health insurance agents indicate that some mid-size employers have difficulties accessing coverage due to risk selection practices of some insurers.[8,9] Proponents also suggest that issues such a premium rate limitations and disclosure requirements could be tailored to meet the needs of mid-size employers in order to achieve greater choice while mitigating the impact on rates, available product designs, and variety of health delivery systems. There is not, however, a clear consensus that access to coverage options is a major problem in the mid-size market.[10]

---

[3] Schauffler HH, Brown ER and Rice T, "The State of Health Insurance in California", University of California for the California Wellness Foundation, January 1997.

[4] "Approaches for Providing/Financing Health Care for the Uninsured: An Assessment of State Options and Experiences", Alpha Center, August 1997.

[5] The State of Washington's Insurance Commission had not approved rate increases since 1993 in this market so this rate increase reflects several years of increasing costs.

[6] Wen P, "Law Ensures Health Care, But at a Cost: New Measure Guarantees Coverage, But Some Object to Price Increases", *The Boston Globe*, November 3, 1997, B1.

[7] KPMG Peat Marwick data suggests that 42% of covered employees in firms of 50-199 have no choice, compared to 66.4% of covered employees in firms of 1-49 and 21.9% in firms of 200-999.

[8] Op-cit., Schauffler HH, Brown ER, and Rice T, "The State of Health Insurance in California, 1996, January 1997.

[9] California Association of Health Underwriters, "Questions and Answers About CAHU's Position on SB-393/SB-1281", May 7, 1997. In addition, MRMIB indicates that it cannot expand the HIPC to offer mid-size employers more choice unless small group reforms are extended to the mid-size market. The California Small Business Association along with some health plans, agents and brokers, medical association and consumer groups support mid-size market reforms.

[10] Industry representatives oppose expanding small group reforms as unnecessary. They argue that such restrictions may reduce the current choice of product designs available in the mid-size market if health plans sought to avoid the requirement

IV. PURCHASING GROUPS

One way to expand choice of plans is to expand access to purchasing groups. Purchasing groups act like sophisticated benefits managers of large corporations for multiple employers. They facilitate multiple choice of plan at the individual or family level.

"Purchasing group" is the generic term used to describe several types of organizations defined by law. California law distinguishes between two types of purchasing groups: purchasing alliances and marketing groups. Marketing groups, in general, act like purchasing alliances, but do not contract directly with plans or employers and do not transfer funds among them. The Department of Corporations (DOC) regulates marketing groups, and the Department of Insurance (DOI) regulates purchasing.

The Health Insurance Plan of California (HIPC), established in 1993 through AB 1672, is a state-run purchasing alliance, open to all small employers with between two and 50 employees, specifically designed to address the administrative problems small employers have in offering access to coverage and multiple choice of plans. However, HIPC growth has been disappointing relative to the size of the small group market. After four years of operation, it covers only about 130,000 people. Theories abound about the reasons behind the limited growth of the HIPC. They include (1) insufficient or inappropriate marketing effort; (2) lack of broker/agent support; (3) the fact that purchasing groups are a new idea, the virtues of which may not be well appreciated or understood by many; and (4) the fact that the HIPC may offer too much choice which may be overwhelming to some. The HIPC is in the process of being privatized over the next several years, pursuant to the provisions of AB 1672.

With existing purchasing group activity, California has more employees in purchasing groups than any other state. However, despite this activity, purchasing groups are not available in many segments of the market. One barrier to entry in the mid-size market may be the lack of market rules, which may expose purchasing groups to adverse risk selection by non-participating insurers, who could deny or discourage enrollment by setting high premiums for employers with unattractive risk profiles, driving them disproportionately into the purchasing groups.

Marketing groups that testified before the Task Force indicated that the regulatory hurdles to becoming a marketing group through the DOC are high.[11] Challenges arise because (1) employers contracting with health plans through a marketing group must contract with each plan separately, (2) health plans participating in marketing groups can not jointly file coordinated documents with the regulatory authority, rather each plan must file separately, and (3) participating plans are required to disclose to employers and employees details of all the benefit packages they offer even if an employer only provides coverage through a purchasing group that offers standard benefit packages. DOC requirements differ from those associated with becoming a purchasing alliance under the DOI. However, plans participating in purchasing alliances must also disclose details of all benefit packages they offer.

V. TASK FORCE RECOMMENDATIONS

A. Expand Choice of Plan

---

to offer, market, sell, and distribute information on all products to all employers. In addition, they argue that increased regulation of health plans in this market could encourage more employers to self-insure, enabling them to avoid all state regulation of their health benefits.

[11] Testimony presented or given to the Managed Health Care Improvement Task Force by Benefits Alliance and California Choice.

Expanding consumer choice of plan is a widely-supported goal among Task Force members and the public. For example, a case can be made that a desirable minimum standard for choice would be two closed-end HMOs (so that there is price competition in this low-priced segment, and so people desiring or needing a low-priced plan have a choice), plus one wide access product (e.g., POS, PPO) (so that anyone who chooses can access any provider, and so nobody is an involuntary HMO member). This is, in effect, what the 1973 HMO Act required.

However, there is little consensus about how to expand choice of plans. This Task Force considered recommending that the federal government require employers that offer coverage to offer employees a choice of plans, but rejected the idea because it would unfairly burden employers who voluntarily provide coverage and might cause them to reduce or drop coverage.

1. The Task Force recommends that public and private purchasers should, whenever feasible, offer consumers a choice of high quality health plans, including choices through purchasing groups where accessible. In addition, the US Congress and the California State Legislature should continue to seek ways to expand coverage and choices of plans.

B. Expand Purchasing Groups

One way to expand individual choice of plans is to expand access to purchasing groups.

2. The Task Force recommends that the state make it a matter of public policy to facilitate and encourage the development of purchasing groups (both marketing groups and purchasing alliances) for small and medium size employers. The applicable state entity for regulation of managed care[12] should work continuously to simplify the process of, and eliminate barriers to, purchasing group formation and make recommendations for changes to the Legislature if necessary. Appropriate measures for the DOC and DOI may vary.

3. The Task Force recommends that guaranteed issue, plan design disclosure, and premium rating limitations for employers with 51-100 employees like those in effect for the 2-50 group market be enacted so that purchasing groups can form, flourish, and obtain a wide variety of participants in the mid-size market, protected from the adverse selection they would be likely to suffer without these provisions.

C. Expanding Access to Providers and Treatment

Refer to Task Force paper on Physician-Patient Relationship for a recommendation to improve continuity of care for consumers undergoing treatment and the Task Force paper on Dispute Resolution Processes for recommendations to establish independent third-party review.

4. A working group of stakeholders[13] should be convened to examine the issue of how to increase consumer choice of providers on a cost neutral basis.

[12] The Department of Corporations, the Department of Insurance, or their successor.

[13] The intention of the Task Force is that stakeholders include, but are not limited to, consumer groups, including representatives of vulnerable populations, providers, provider groups, health plans, and purchasers.